State of Maryland
Department of Health and Mental Hygiene

John M. Colmers
Chairman

Herbert S. Wong, Ph.D.
Vice-Chairman

George H. Bone,
M.D.

Stephen F. Jencks,
M.D., M.P.H.

Jack C. Keane

Bernadette C. Loftus,
M.D.

Thomas R. Mullen

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Donna Kinzer
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

David Romans
Director
Payment Reform
and Innovation

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Sule Calikoglu, Ph.D.
Deputy Director
Research and Methodology

517th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
March 11, 2015

EXECUTIVE SESSION
12:00 p.m.
(The Commission will begin in public session at 12:00 p.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1PM.)

1. **Status of Medicare Data Submission and Reconciliation – Authority General Provisions Article, § 3-104**
2. **Contract and Modeling of the All-payer Model and Legal Consultation on Potential Alternate Medicare Payment for Hospital Services vis-a-vis the All-Payer Model Contract – Authority General Provisions Article, § 3-104, and 3-305(b)(7)**
3. **Personnel Issues – Authority General Provisions Article, § 3-305(b)(1)(i)(ii)**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Minutes from the Executive Session and Public Meeting on February 11, 2015**

2. **Executive Director's Report**

3. **New Model Monitoring**

4. **Docket Status – Cases Closed**
   2287A- University of Maryland Medical Center
   2284R – Garrett County Memorial Hospital
   2285R - Johns Hopkins Bayview Medical Center

5. **Docket Status – Cases Open**
   2288R - MedStar Southern Maryland Hospital Center
   2289R – MedStar Franklin Square Hospital Center
   2290A - University of Maryland Medical Center
   2291A – Johns Hopkins Health System
   2292A – Johns Hopkins Health System
   2293A – Johns Hopkins Health System

6. **Final Recommendation for Modifications to the Readmission Reduction Incentive Program for FY 2017**

7. **Final Recommendations for Total Amount at Risk for Quality Programs for FY 2017**

8. **Draft Recommendation for Funding of Statewide Infrastructure, and Planning of Regional Partnerships for Health System Transformation**

9. **Demonstration of MHCC's Web-based Consumer Guide**

10. **Work Group Updates**

11. **Legislative Report**

12. **Legal Report**

13. **Hearing and Meeting Schedule**

Minutes to be included after Commissioner’s Approval

Executive Director's Report

The Executive Director's Report will be distributed during the Commission Meeting

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

Cases Closed

The closed cases from last month are listed in the agenda

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF MARCH 3, 2015

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2288R	MedStar Southern Maryland Hospital Center	1/29/2015	2/28/2015	6/29/2015	DEF/MSG	CK	OPEN
2290R	MedStar Franklin Square Hospital Center	1/29/2015	2/28/2015	6/29/2015	DEF/MSG	CK	OPEN
2290A	University of Maryland Medical Center	1/14/2015	N/A	N/A	N/A	DNP	OPEN
2291R	Johns Hopkins Health System	2/27/2015	N/A	N/A	N/A	DNP	OPEN
2292A	Johns Hopkins Health System	2/27/2015	N/A	N/A	N/A	DNP	OPEN
2293R	Johns Hopkins Health System	2/27/2015	N/A	N/A	N/A	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*	**COST REVIEW COMMISSION**
MEDSTAR SOUTHERN MARYLAND	*	**DOCKET: 2015**
HOSPITAL CENTER	*	**FOLIO: 2098**
CLINTON, MARYLAND	*	**PROCEEDING: 2288R**

Staff Recommendation

March 11, 2015

Introduction

On January 29, 2015, MedStar Southern Maryland Hospital Center (the "Hospital"), a member of MedStar Health, submitted a partial rate application to the Commission requesting its July 1, 2014 Medical Surgical Acute (MSG) and Definitive Observation (DEF) approved rates be combined effective March 1, 2015.

Staff Evaluation

This rate request is revenue neutral and will not result in any additional revenue for the Hospital as it only involves the combining of two revenue centers. The Hospital wishes to combine these two centers, because the patients have similar staffing needs. DEF patients are cared for in the same area as MSG patients, and nursing to patient staffing ratios for both patient populations are very similar. The Hospital's currently approved rates and the new proposed rate are as follows:

	Current Rate	Budgeted Volume	Approved Revenue
Medical Surgical Acute	$841.45	18,467	$15,539,026
Definitive Observation	$992.82	24,245	$24,070,869
Combined Rate	$927.37	42,712	$39,609,895

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That the Hospital be allowed to collapse its DEF rate into its MSG rate;

2. That a MSG rate of $927.37 per day be approved effective March 1, 2015; and

3. That no change be made to the Hospital's Global Budget Revenue for MSG services.

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*	**COST REVIEW COMMISSION**
MEDSTAR FRANKLIN SQUARE	*	**DOCKET: 2015**
MEDICAL CENTER	*	**FOLIO: 2099**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2289R**

Staff Recommendation

March 11, 2015

Introduction

On January 29, 2015, MedStar Franklin Square Medical Center (the "Hospital"), a member of MedStar Health, submitted a partial rate application to the Commission requesting its July 1, 2014 Medical Surgical Acute (MSG) and Definitive Observation (DEF) approved rates be combined effective March 1, 2015.

Staff Evaluation

This rate request is revenue neutral and will not result in any additional revenue for the Hospital as it only involves the combining of two revenue centers. The Hospital wishes to combine these two centers, because the patients have similar staffing needs. DEF patients are cared for in the same area as MSG patients, and nursing to patient staffing ratios for both patient populations are very similar. The hospital's currently approved rates and the new proposed rate are as follows:

	Current Rate	Budgeted Volume	Approved Revenue
Medical Surgical Acute	$1,305.55	46,398	$60,574,724
Definitive Observation	$1,164.70	15,018	$17,491,439
Combined Rate	$1,271.10	61,416	$78,066,163

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That the Hospital be allowed to collapse its DEF rate into its MSG rate;
2. That a MSG rate of $1,271.10 per day be approved effective March 1, 2015; and
3. That no change be made to the Hospital's Global Budget Revenue for MSG services.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION *		**COMMISSION**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2015**
MEDICAL CENTER *		**FOLIO: 2100**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2290A**

Staff Recommendation

March 11, 2015

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on January 30, 2015 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. Network for a period of one year, effective April 1, 2015.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI). UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital component of the global rates was developed by calculating mean historical charges for patients receiving like procedures. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement among UPI, the Hospital, and the physicians holds the Hospital harmless from any shortfalls in payment from the global price contract. UPI maintains it has been active in similar types of fixed fee contracts for several years, and that UPI is adequately capitalized to the bear the risk of potential losses.

V. STAFF EVALUATION

Staff reviewed the experience under this arrangement for the last year and found it to be favorable. After review of the application and additional information provided by the Hospital,

staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

V I. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. for a one year period commencing April 1, 2015. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: **THE APPLICATION FOR**	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2015**
SYSTEM	*	**FOLIO:**	**2101**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2291A**

Staff Recommendation

March 11 2015

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on February 25, 2015 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to participate in a global rate arrangement for joint replacement services with Health Design Plus, Inc. for Pacific Business Group on Health clients for a period of one year beginning April 1, 2015.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving similar joint replacement at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under this arrangement over the last year has been

favorable. Therefore, staff recommends approval of the Hospitals' request.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement services for a one year period commencing April 1, 2015. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: **THE APPLICATION FOR**	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2015**
SYSTEM	*	**FOLIO:**	**2102**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2292A**

Staff Recommendation

March 11, 2015

I. INTRODUCTION

Johns Hopkins Health System (the “System”) filed an application with the HSCRC on February 25, 2015 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to participate in a global rate arrangement for joint replacement and cardiovascular services with Health Design Plus, Inc. for clients other than those of Pacific Business Group on Health clients for a period of one year beginning April 1, 2015.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving similar joint replacement and cardiovascular procedures at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Although there has been no activity to date, staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement and cardiovascular services for a one year period commencing April 1, 2015. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Final Recommendation for Modifications to the Readmission Reduction Incentive Program for FY 2017

This recommendation will be sent separately over the next few days

Final Recommendation for Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2017

Health Services Cost Review Commission
4160 Patterson Avenue Baltimore, MD 21215
(410) 764-2605

March 11, 2014

This document contains the final staff recommendations for the aggregate amount at-risk under Maryland hospital quality programs for Rate Year 2017.

I. Introduction

The HSCRC quality-based payment methodologies are important policy tools with great potential to provide strong incentives for hospitals to improve their quality performance over time. Each of the current policies for quality-based payment programs holds revenue at risk directly related to specified performance targets.

- The Quality Based Reimbursement (QBR) program employs measures in several domains, namely clinical process of care, patient experience, outcomes and safety similar to the Medicare Value Based Purchasing program (VBP). Since the beginning of the program financial adjustments have been based on revenue neutral scaling of hospitals in allocating rewards and reductions based on performance, with the net increases in rates for better performing hospitals funded by net decreases in rates for poorer performing hospitals.[1] The distribution of rewards/penalties have been based on relative points achieved by the hospitals and are not known before the end of performance period.

- The Maryland Hospital Acquired Conditions (MHAC) program measures hospital performance using potentially preventable complications observed to expected ratios compared to statewide benchmarks for each complication and revenue allocations are performed using pre-established performance targets. The revenue at risk and reward structure is based on a tiered approach that requires statewide targets to be met for higher rewards and lower reductions.

- The Readmission Reduction Incentive Program (RRIP) policy initiated in RY 2015 is designed to be a positive incentive program to reward hospitals that achieve a specified readmission reduction target. The statewide target is established to eliminate the gap between the national Medicare readmission rate and Maryland Medicare readmission rate. For RY 2017, staff is proposing to strengthen this program by increasing the amount of revenue at risk and including both rewards and reductions.[2]

- In addition to the three programs where hospital performance is measured for base and performance periods, two additional quality payment adjustments are implemented to hospital revenues prospectively. The Readmission Shared Savings Program reduces each hospital's approved revenues prospectively based on its risk adjusted readmission rates. Potentially Avoidable Utilization efficiency reductions are applied to global budgets to reduce allowed volume growth based on percent of revenue associated with potentially avoidable utilization for each hospital.

[1] The term "scaling" refers to the differential allocation of a pre-determined portion of base regulated hospital revenue contingent on assessment of the relative quality of hospital performance. The rewards (positive scaled amounts) or reductions (negative scaled amounts) are then applied to each hospital's revenue on a "one-time" basis (and not considered permanent revenue).

[2] Please see "Final Recommendation for Updating the Hospital Readmission Reduction Incentive Program for Rate Year (RY) 2017" for details.

This final recommendation proposes changes for the amount of hospital revenue at-risk and scaling methodologies for the following programs: 1. Quality-Based Reimbursement; 2. Maryland Hospital Acquired Conditions; and, 3. Readmission Reduction Incentive Program.

The Shared Savings for Readmissions Policy[3] and Potentially Avoidable Utilization global budget efficiency reductions that also hold revenue at risk based on performance are determined annually commensurate with the hospital rate update factor process.

II. Background

Maryland has been a leader in initiating quality based payment approaches. Historically, these programs have surpassed the requirements of similar federal programs and as a result Maryland has been exempt from the federal programs. When Maryland entered into the All-Payer Model Agreement with CMS effective January 1, 2014, the continuing exemption process was addressed in the Agreement. The Agreement requires that the proportion of Maryland hospitals' revenues held at risk for quality programs be equal to or greater than the proportion of revenue that is held at risk under national Medicare programs. The objective of this requirement is two-fold: a) incentivize hospitals to deliver high quality care in support of the Triple Aim of better care, better health, and lower cost, and b) evaluate the extent to which Maryland quality programs are rewarding value as compared to those of the national Medicare program. The relevant agreement language is as follows.

> *Regulated Revenue at risk: [Maryland] must ensure that the aggregate percentage of Regulated Revenue at risk for quality programs administered by the State is equal to or greater than the aggregate percentage of revenue at risk under national Medicare quality programs. Quality programs include, but are not limited to, readmissions, hospital acquired conditions, and value-based purchasing programs.*

It is important to note that under the All-Payer Model Agreement, Maryland is required to achieve specific reduction targets in total cost of hospital care, potentially preventable conditions, and readmissions in addition to its revenue at risk requirement. In an effort to meet these reduction targets, Maryland restructured its quality programs in such a way that financial incentives are established prior to the performance period in order to motivate quality improvement and sharing of best practices while holding hospitals accountable for their performance.

For RY 2016 following maximum amounts of revenue at-risk were already approved by the Commission:

- QBR: 1% maximum penalty, with revenue neutral scaled rewards up to 1%.
- MHAC—4%maximum penalty if statewide improvement target is not met; 1% maximum penalty and revenue neutral rewards up to 1% if statewide improvement target is met.
- RRIP—0.5% positive incentive for any hospital that improves all payer readmission rate by at least 6.76%.

During the upcoming annual revenue update process for RY 2016, HSCRC staff expects that two additional quality adjustments will be applied. The following adjustments were applied in RY2015 rates:

[3] For the Readmission Shared Savings adjustment, the HSCRC calculates a case mix adjusted readmission rate for each hospital for the base period and determines a statewide required percent reduction in readmission rates to achieve the revenue for shared savings. Current policy is posted at: http://hscrc.maryland.gov/init-shared-savings.cfm

- Readmissions Shared Savings Program—A savings of 0.4% total hospital revenue (approximating an average 0.60% and maximum reduction of 0.86% of inpatient revenue) based on risk adjusted readmission levels.
- PAU Reduction Program—A reduction of allowed revenue for volume increases associated with potentially avoidable utilization that had a maximum revenue reduction of 0.86% and an average reduction of 0.30% of inpatient revenue.

III. Assessment

a. Aggregate Revenue At-Risk Comparison with Medicare Programs

Currently staff is in discussions with CMMI regarding the methodology for comparing the Maryland aggregate amount of revenue at risk and the national Medicare aggregate amount-at-risk provided for in the Agreement. In addition to calculating maximum at risk ("potential risk"[4]), CMMI staff expressed a need to measure the actual revenues impacted by the programs ("realized risk"). Discussions on "realized risk" are in progress.

CMMI staff proposed that measurement of both the potential and realized aggregate percentage of revenue at-risk occur annually across all quality programs comparing the State fiscal year (July 1 – June 30) to the Federal fiscal year (October 1 – September 30). For example, Maryland's SFY 2015 (July 2014 – June 2015) will be evaluated against CMS' FFY 2015 (October 2014 – September 2015). Some Maryland quality program adjustments are applied to both inpatient and outpatient revenue. For these programs, outpatient revenues at risk will be converted to an equivalent inpatient revenue base (Formula: percent of revenue at risk/percent inpatient revenue). Where applicable, both upside and downside risk will be considered. CMMI staff accepted to include all current measures, including PAUs in Maryland's aggregate at risk amount totals.

Based upon this proposal, Figure 1 shows the potential risk for each quality program and in aggregate for Maryland and Medicare, as well as the cumulative difference between Maryland and Medicare from 2014 to 2016.

[4] Potential risk is defined as maximum percentage of revenue that an individual hospital stands to gain or lose based on their performance within a given quality program.

Figure 1: Maryland Versus Medicare Quality Programs' Potential Revenue at Risk, 2014-2016

Maryland - Potential Inpatient Revenue at Risk absolute values

% Inpatient Revenue	SFY 2014	SFY 2015	SFY2016	SFY2017 (Proposed/ estimated)
MHAC	2.0%	3.0%	4.0%	**3.0%**
RRIP			0.5%	**2.0%**
QBR	0.50%	0.50%	1.00%	**2.0%**
Shared Savings[5]	0.41%	0.86%	***0.86%***	***0.86%***
GBR PAU:	0.50%	0.86%	***0.86%***	***0.86%***
MD Aggregate Maximum At Risk	3.41%	5.22%	7.22%	8.72%

Blue are estimated numbers based on current policy.

Medicare National - Potential IP revenue at risk absolute values

% IP Rev	FFY 2014	FFY 2015	FFY2016	FFY2017
HAC		1.00%	1.00%	1.00%
Readmits	2.00%	3.00%	3.00%	3.00%
VBP	1.25%	1.50%	1.75%	2.00%
Medicare Aggregate Maximum At Risk	3.25%	5.50%	5.75%	6.00%

Annual MD-US Difference	0.16%	-0.28%	1.47%	2.72%
Cumulative MD-US Difference			**1.19%**	**4.19%**

Staff discussed two alternative methods to measure realized risk with the CMMI. One option is to compare Maryland and Medicare hospital average percent revenue allocated in quality programs by taking the average of absolute value of revenue adjustments within each program. A second option is to calculate the total revenue adjustments as a percent of total inpatient revenue in the state by summing all absolute values in each program and dividing the result by the state total inpatient revenue. Staff calculated Maryland and Medicare percentages for FY2015 for these options (see Figure 2), revealing that Maryland is slightly above Medicare in terms of average absolute percent for FY2015. Since the payment adjustments are highly depended on hospital performance in the measurement period, it's not possible to calculate realized at risk totals for future years.

[5] Staff will consider the shared savings policy adjustment together with the new RRIP program in conjunction with the balanced update.

Figure 2. Maryland versus Medicare Quality Programs Realized Revenue at Risk, 2015

Maryland: (SFY 15)

%tile (FY 15)	MHAC	Readmits	QBR	GBR PAU	Sum with PAU
100%	0.13%	-0.08%	0.28%	0.00%	
75%	0.06%	-0.59%	0.08%	-0.14%	
50%	0.05%	-0.64%	0.01%	-0.29%	
25%	0.02%	-0.72%	-0.15%	-0.44%	
0%	-1.00%	-0.86%	-0.50%	-0.86%	
FY 15 Absolute % Average	**0.11%**	**0.64%**	**0.14%**	**0.29%**	**1.18%**
FY 15 Total Value Percent	**0.09%**	**0.67%**	**0.13%**	**0.22%**	**1.11%**

CMS National: (FFY 15)

%tile (FY 15)	HAC	Readmits	VBP	Sum
100%	0.00%	0.00%	1.06%	
75%	0.00%	-0.06%	0.15%	
50%	0.00%	-0.31%	0.00%	
25%	0.00%	-0.77%	-0.21%	
0%	-1.00%	-3.00%	-1.37%	
FY 15 Absolute % Average	**0.22%**	**0.52%**	**0.24%**	**0.97%**

b. Scaling Methodology Changes

i. Relative vs Preset Scaling

There is general agreement that the scaling methodologies for the quality programs should use a preset scale, and should not rank hospitals relative to each other based on the concurrent measurement scores; this is to provide predictable benchmarks, and to promote collaboration to improve quality of care. A similar change was already approved last year by the Commission for the RY 2016 MHAC program, and hospitals were never ranked for the RRIP as it was based on a fixed amount of reward for hospitals that achieved the readmission reduction target. Thus the only program currently using relative scaling is the QBR program, and staff has received positive feedback from both the payment models and performance measurement workgroups on changing the QBR program to a preset point scale for rate year 2017.

ii. Revenue Neutrality

Staff have also discussed with the workgroups changing the reward and penalty structures to not be revenue neutral. This change would mean the net aggregate impact of quality program adjustments may either be positive or negative. A methodology that requires revenue neutrality restricts the aggregate amount for the rewards to the aggregate amount collected through reductions in a given program. Commission approved removing this cap for RY 2017 MHAC program at the January 2015 meeting. Based on the preliminary analysis for results for RY 2016 MHAC, it is likely that, under the

revenue neutrality adjustment, hospitals that would receive rewards will receive 5% or less of the total reward they should have earned. Workgroup members discussed the impact of a revenue neutrality adjustment to the quality programs, specifically noting that limiting the rewards to the penalties collected does not recognize the efforts expended to achieve the performance levels for the better performing hospitals. Based upon these discussions, staff supports removing the cap on rewards for RY 2016 as well.

iii. Maximum Revenue at Risk Hospital Guardrail

As we increase the maximum revenue adjustments statewide, concerns have been raised about the potential for a particular hospital to receive large revenue reductions that may cause unmanageable financial risk for a particular hospital in the state. As hospitals improve quality in the state, the variation between individual hospitals is expected to lessen increasing the chances of a single hospital receiving maximum penalties from all programs. According to simulations staff performed, the maximum penalty one hospital may receive may go up as much as 4.4% of the inpatient revenue (Figure 3) in RY 2017 based on the proposed maximum revenues at risk. The summary results of these simulations are provided in the Appendix for each program. Similar to the risk corridors in other value-based purchasing programs, maximum penalty guardrail may be necessary to mitigate the detrimental financial impact of unforeseen large adjustments in Maryland programs. A statewide guardrail was put in place for the MHAC program for RY 2016 based on similar concerns last year. Given the increases in risk levels in other programs, a hospital specific guardrail will provide a better protection than a state-wide limit. As the state increases the revenues associated with the quality based programs and implements national benchmarks, the maximum revenue at risk guardrail will need to be updated in parallel.

Figure 3: Estimated Aggregate Impact of Maryland Quality Based Programs

		Statewide Total Penalties	Statewide Total Rewards	Net Revenue Impact
Program Specific Impact		**C1**	**C2**	**C1+C2 = C3**
MHAC Below Target	**L1**	-$123,076,937	$0	-$123,076,937
MHAC (8% Improvement)	**L2**	-$16,997,460	$3,906,130	-$13,091,330
RRIP (Continuous Scale)	**L3**	-$22,052,191	$15,492,625	-$6,559,566
QBR (Preset Scaling)	**L4**	-$25,015,762	$21,335,875	-$3,679,887
Net Impact				
MHAC (Below Target)	**L5**	-$136,615,973	$3,299,583	-$133,316,391
Percent Inpatient Revenue	**L6**	-1.5%	0.0%	-1.5%
Percent Total Revenue	**L7**	-0.9%	0.0%	-0.9%
Maximum Hospital Specific Adjustment	**L8**	**-4.4%**	**2.0%**	
MHAC (8% Improvement)	**L9**	-$39,716,213	$16,385,430	-$23,330,783
Percent Inpatient Revenue	**L10**	-0.4%	0.2%	-0.3%
Percent Total Revenue	**L11**	-0.3%	0.1%	-0.2%
Maximum Net Impact as Percent Inpatient	**L12**	**-2.5%**	**2.4%**	

IV. Recommendations

Based upon the above assessment, current quality results for CY2014 YTD, and discussions with CMMI on our quality programs, staff's position and rationale for revenue amounts at-risk and scaling methodology for RY2017 are outlined below. Staff is determining the maximum at risk amounts according to the specifics of each program and ensuring that we fulfill the requirements of the contract rather than using the Medicare aggregate amounts at risk as the target amounts for value-based purchasing.

1. **QBR**: 2% maximum penalty.

   This matches Medicare's VBP program and increases the incentive for hospitals to improve HCAHPS scores, which continue to be low compared to the Nation. Staff recommend that a preset scale be used, and that rewards and penalties not be revenue neutral starting with RY 2017 results.

2. **MHAC**: 3%maximum penalty if statewide improvement target is not met; 1% maximum penalty and up to 1% if statewide improvement target is met.

   The reduction from 4% to 3% recognizes the improvements that were made in CY2014, but continues to place a significant amount of revenue at-risk to ensure continued quality improvement

3. Staff recommends removing the revenue neutrality requirement for the rate year RY 2016 to recognize the large improvements in PPCs achieved by the hospitals during this performance period.

4. **RRIP**: 2% scaled maximum penalty and 1% reward for hospitals that reduce readmission rates at or better than the minimum improvement.

   The decision to add reductions and increase potential rewards is based on staff and stakeholder concerns regarding the CY2014 YTD improvement.

5. **Maximum penalty guardrail:** Hospital maximum penalty guardrail to be set at 3.5% of total revenue for RY2017.

   Staff used Medicare aggregate amount at risk total as the benchmark for calculating hospital maximum penalty guardrail (e.g. 6% x %Percent Inpatient Revenue).

Appendix 1: RRIP Modeling Results for RY 2017

2. Readmission Reduction Program Modeling for FY2017									RRIP Proposed Scaling for FY2017		
HOSPITAL ID	HOSPITAL NAME	CY 13 YTD Risk Adjusted Readmission Rate	PERCENT CHANGE in CY 14 IN RISK ADJUSTED RATE	FY16 Scaling	FY16 Reward	CY 15 ESTIMATED CUMULATIVE REDUCTION	TARGET	Over/Under Target	FY 17 Scaling	FY 17 Adjustment	Revenue Savings from Reductions
A	B	D	F	H	I	J	L	M	N	O	Q
210045	MCCREADY	11.53%	-22.16%	0.50%	$18,673	**-26.7%**	-9.5%	-17.2%	1.00%	$37,346	$114,747
210013	BON SECOURS	18.45%	-15.69%	0.50%	$391,064	**-20.6%**	-9.5%	-11.1%	1.00%	$782,128	$2,966,426
210028	ST. MARY	12.21%	-15.09%	0.50%	$347,602	**-20.0%**	-9.5%	-10.5%	1.00%	$695,203	$1,696,075
210051	DOCTORS COMMUNITY	12.37%	-13.23%	0.50%	$681,127	**-18.2%**	-9.5%	-8.7%	1.00%	$1,362,254	$3,074,119
210039	CALVERT	9.41%	-12.52%	0.50%	$336,926	**-17.6%**	-9.5%	-8.1%	0.92%	$621,982	$1,113,914
210030	CHESTERTOWN	13.37%	-11.86%	0.50%	$147,083	**-16.9%**	-9.5%	-7.4%	0.85%	$250,607	$666,505
210024	UNION MEMORIAL	13.91%	-10.41%	0.50%	$1,212,528	**-15.6%**	-9.5%	-6.1%	0.70%	$1,686,873	$5,252,823
210055	LAUREL REGIONAL	13.18%	-9.59%	0.50%	$387,510	**-14.8%**	-9.5%	-5.3%	0.61%	$470,350	$1,511,973
210063	UM ST. JOSEPH	11.42%	-9.06%	0.50%	$1,081,676	**-14.3%**	-9.5%	-4.8%	0.55%	$1,190,190	$3,535,780
210011	ST. AGNES	13.40%	-8.81%	0.50%	$1,195,608	**-14.1%**	-9.5%	-4.6%	0.52%	$1,251,767	$4,509,573
210018	MONTGOMERY GENERAL	12.06%	-8.55%	0.50%	$438,261	**-13.8%**	-9.5%	-4.3%	0.49%	$433,863	$1,461,955
210008	MERCY	14.07%	-8.30%	0.50%	$1,165,818	**-13.6%**	-9.5%	-4.1%	0.47%	$1,092,139	$4,460,399
210040	NORTHWEST	14.09%	-8.15%	0.50%	$710,934	**-13.5%**	-9.5%	-4.0%	0.45%	$643,411	$2,695,390
210003	PRINCE GEORGE	10.00%	-7.36%	0.50%	$886,216	**-12.7%**	-9.5%	-3.2%	0.37%	$650,508	$2,252,404
210012	SINAI	13.60%	-7.02%	0.50%	$2,145,773	**-12.4%**	-9.5%	-2.9%	0.33%	$1,418,519	$7,230,111
210038	UMMC MIDTOWN	15.99%	-6.54%	0.00%	$0	**-11.9%**	-9.5%	-2.4%	0.28%	$372,249	$2,551,708
210044	G.B.M.C.	10.63%	-6.53%	0.00%	$0	**-11.9%**	-9.5%	-2.4%	0.28%	$559,435	$2,555,145
210023	ANNE ARUNDEL	12.06%	-6.37%	0.00%	$0	**-11.8%**	-9.5%	-2.3%	0.26%	$805,997	$4,400,852
210017	GARRETT COUNTY	7.03%	-6.08%	0.00%	$0	**-11.5%**	-9.5%	-2.0%	0.23%	$42,880	$151,333
210029	HOPKINS BAYVIEW MED CTR	14.57%	-5.56%	0.00%	$0	**-11.0%**	-9.5%	-1.5%	0.17%	$615,946	$5,717,315
210056	GOOD SAMARITAN	13.63%	-5.11%	0.00%	$0	**-10.6%**	-9.5%	-1.1%	0.12%	$225,290	$2,609,338
210034	HARBOR	12.88%	-4.87%	0.00%	$0	**-10.4%**	-9.5%	-0.9%	0.10%	$121,813	$1,654,675
210048	HOWARD COUNTY	11.77%	-4.86%	0.00%	$0	**-10.3%**	-9.5%	-0.8%	0.10%	$161,876	$2,037,839
210062	SOUTHERN MARYLAND	11.35%	-3.53%	0.00%	$0	**-9.1%**	-9.5%	0.4%	-0.05%	-$76,309	$1,683,664
210027	WESTERN MARYLAND HEALTH SYS	11.91%	-3.03%	0.00%	$0	**-8.6%**	-9.5%	0.9%	-0.10%	-$184,589	$1,895,597
210043	BALTIMORE WASHINGTON MEDIC	13.66%	-3.01%	0.00%	$0	**-8.6%**	-9.5%	0.9%	-0.10%	-$229,520	$2,622,108
210057	SHADY GROVE	10.79%	-2.90%	0.00%	$0	**-8.5%**	-9.5%	1.0%	-0.11%	-$260,981	$2,098,281
210058	REHAB & ORTHO	11.64%	-2.48%	0.00%	$0	**-8.1%**	-9.5%	1.4%	-0.16%	-$110,068	$652,199
210022	SUBURBAN	10.89%	-2.35%	0.00%	$0	**-8.0%**	-9.5%	1.5%	-0.17%	-$314,171	$1,577,347
210061	ATLANTIC GENERAL	11.42%	-2.33%	0.00%	$0	**-8.0%**	-9.5%	1.5%	-0.18%	-$67,929	$351,397
210002	UNIVERSITY OF MARYLAND	13.80%	-1.94%	0.00%	$0	**-7.6%**	-9.5%	1.9%	-0.22%	-$1,881,126	$9,055,047
210015	FRANKLIN SQUARE	12.66%	-1.88%	0.00%	$0	**-7.5%**	-9.5%	2.0%	-0.22%	-$639,789	$2,727,485
210033	CARROLL COUNTY	11.77%	-1.46%	0.00%	$0	**-7.1%**	-9.5%	2.4%	-0.27%	-$372,061	$1,162,586
210060	FT. WASHINGTON	12.41%	-1.13%	0.00%	$0	**-6.8%**	-9.5%	2.7%	-0.30%	-$54,143	$150,866
210009	JOHNS HOPKINS	13.95%	-0.46%	0.00%	$0	**-6.2%**	-9.5%	3.3%	-0.38%	-$4,878,181	$11,186,553
210032	UNION HOSPITAL OF CECIL COUN	9.97%	-0.14%	0.00%	$0	**-5.9%**	-9.5%	3.6%	-0.41%	-$279,210	$399,301
210006	HARFORD	10.99%	-0.10%	0.00%	$0	**-5.9%**	-9.5%	3.6%	-0.42%	-$196,225	$303,137
210049	UPPER CHESAPEAKE HEALTH	11.27%	0.66%	0.00%	$0	**-5.1%**	-9.5%	4.4%	-0.50%	-$742,075	$863,459
210010	DORCHESTER	10.86%	0.90%	0.00%	$0	**-4.9%**	-9.5%	4.6%	-0.52%	-$131,821	$134,203
210005	FREDERICK MEMORIAL	10.37%	1.77%	0.00%	$0	**-4.1%**	-9.5%	5.4%	-0.62%	-$1,171,437	$805,182
210001	MERITUS	11.18%	2.61%	0.00%	$0	**-3.3%**	-9.5%	6.2%	-0.71%	-$1,328,446	$693,233
210019	PENINSULA REGIONAL	10.66%	3.23%	0.00%	$0	**-2.7%**	-9.5%	6.8%	-0.78%	-$1,811,871	$679,724
210035	CHARLES REGIONAL	11.46%	4.82%	0.00%	$0	**-1.2%**	-9.5%	8.3%	-0.95%	-$722,556	$107,621
210016	WASHINGTON ADVENTIST	10.79%	4.95%	0.00%	$0	**-1.1%**	-9.5%	8.4%	-0.96%	-$1,553,168	$193,395
210004	HOLY CROSS	11.03%	5.88%	0.00%	$0	**-0.2%**	-9.5%	9.3%	-1.06%	-$3,392,679	$79,569
210037	EASTON	10.44%	12.21%	0.00%	$0	**5.7%**	-9.5%	15.2%	-1.74%	-$1,653,836	-$567,760
		--									
	STATE	**12.45%**	**-3.84%**		**$ 11,146,798**	**-7.7%**	-9.5%			**$ (6,559,566)**	**$ 103,074,594**
	Penalties									$ (22,052,191)	
	Rewards									$ 15,492,625	

CY 14 is based on Jan-October Data

CY15 reductions are estimated to be the same as CY14.

Revenue estimates are based on FY15.

Appendix 2: QBR Scaling Modeling Results for RY 2017

HOSPID	HOSPITAL NAME	Estimated Inpatient Revenue (FY15*2.6%)	QBR FINAL POINTS*	FY 17 Proposed Scaling %	Fy 2017 Proposed Scaling $
A	B	C	D	E	C*E= F
210062	Southern Maryland Hospital Center	$ 163,208,213	0.050	-2.00%	-$3,264,164
210003	Prince Georges Hospital Center	$ 177,243,165	0.110	-1.68%	-$2,979,837
210048	Howard County General Hospital	$ 167,386,497	0.230	-1.04%	-$1,746,915
210013	Bon Secours Hospital	$ 78,212,787	0.251	-0.93%	-$730,176
210019	Peninsula Regional Medical Center	$ 233,728,496	0.269	-0.84%	-$1,956,368
210044	Greater Baltimore Medical Center	$ 201,533,345	0.279	-0.79%	-$1,583,193
210029	Johns Hopkins Bayview Medical Cente	$ 356,396,901	0.285	-0.75%	-$2,678,042
210055	Laurel Regional Hospital	$ 77,501,975	0.294	-0.70%	-$544,137
210060	Fort Washington Medical Center	$ 17,776,133	0.295	-0.70%	-$124,129
210022	Suburban Hospital	$ 181,410,188	0.310	-0.62%	-$1,122,192
210001	Meritus Hospital	$ 187,434,497	0.310	-0.62%	-$1,159,458
210040	Northwest Hospital Center	$ 142,186,717	0.316	-0.59%	-$836,376
210057	Shady Grove Adventist Hospital	$ 228,731,775	0.320	-0.57%	-$1,293,393
210018	Montgomery General Hospital	$ 87,652,208	0.335	-0.49%	-$425,785
210011	St. Agnes Hospital	$ 239,121,556	0.335	-0.49%	-$1,161,572
210015	Franklin Square Hospital Center	$ 285,691,170	0.345	-0.43%	-$1,236,001
210016	Washington Adventist Hospital	$ 161,698,669	0.367	-0.31%	-$508,634
210024	Union Memorial Hospital	$ 242,505,500	0.374	-0.28%	-$669,791
210033	Carroll Hospital Center	$ 138,209,278	0.380	-0.25%	-$340,930
210004	Holy Cross Hospital	$ 319,596,342	0.400	-0.14%	-$448,760
210056	Good Samaritan Hospital	$ 180,861,011	0.405	-0.11%	-$205,909
210061	Atlantic General Hospital	$ 38,640,762	0.426	0.00%	$0
210012	Sinai Hospital	$ 429,154,679	0.446	0.07%	$302,433
210038	Maryland General Hospital	$ 133,787,811	0.451	0.09%	$119,716
210035	Civista Medical Center	$ 76,338,049	0.455	0.11%	$80,358
210034	Harbor Hospital Center	$ 124,002,220	0.469	0.16%	$192,535
210032	Union of Cecil	$ 67,852,189	0.482	0.21%	$139,280
210002	University of Maryland Hospital	$ 863,843,449	0.484	0.21%	$1,828,715
210039	Calvert Memorial Hospital	$ 67,385,287	0.491	0.24%	$161,370
210049	Upper Chesapeake Medical Center	$ 148,917,096	0.495	0.25%	$376,216
210043	Baltimore Washington Medical Center	$ 223,155,126	0.495	0.25%	$563,766
210005	Frederick Memorial Hospital	$ 189,480,763	0.500	0.27%	$513,598
210037	Memorial Hospital at Easton	$ 94,828,132	0.509	0.31%	$289,472
210030	Chester River Hospital Center	$ 29,416,674	0.539	0.41%	$121,539
210051	Doctors Community Hospital	$ 136,225,391	0.540	0.42%	$570,000
210027	Western MD Regional Medical Center	$ 184,484,266	0.589	0.60%	$1,106,900
210008	Mercy Medical Center	$ 233,163,594	0.609	0.67%	$1,568,340
210017	Garrett County Memorial Hospital	$ 18,724,074	0.611	0.68%	$127,128
210023	Anne Arundel Medical Center	$ 310,117,075	0.615	0.69%	$2,154,509
210006	Harford Memorial Hospital	$ 47,089,618	0.632	0.76%	$356,893
210009	Johns Hopkins Hospital	$ 1,292,515,919	0.634	0.76%	$9,864,012
210010	Dorchester General Hospital	$ 25,127,935	0.647	0.81%	$203,891
210028	St. Mary's Hospital	$ 69,520,305	0.698	1.00%	$695,203
	Statewide Total	$8,671,856,840			-$3,679,887
* Based on FY2015 Scores.		Minimum Score	0.05	Total Penalty	-25,015,762
		Median Score	0.43		
		Maxium Score	0.70	Total Rewards	21,335,875

				Scenario 1: Scaling for Below State Quality Target				io 2: Scaling for Exceed Target		
Hospital ID	Hospital Name	Estimated Inpatient Revenue (FY15*2.6%)	Base FY2014 Score	Projected MHAC SCORE For Performance Year with 5 % Improvement	% Adjustment	$ Adjustment	Adjusted Amounts	Projected MHAC SCORE For Performance Year with 8 % Improvement	% Adjustment	$ Adjustment
A	B	C	D	E	F	C*F= G	G/adj ratio = H	I	J	C*J = K
210019	peninsula regional	$233,728,496	0.19	0.22	-2.56%	$ (5,980,700)	$ (2,177,225)	0.27	-0.58%	$ (1,363,416)
210004	holy cross	$319,596,342	0.21	0.22	-2.56%	$ (8,177,906)	$ (2,977,100)	0.27	-0.58%	$ (1,864,312)
210022	suburban	$181,410,188	0.2	0.23	-2.47%	$ (4,481,899)	$ (1,631,599)	0.27	-0.58%	$ (1,058,226)
210062	southern maryland	$163,208,213	0.23	0.24	-2.38%	$ (3,888,196)	$ (1,415,466)	0.29	-0.50%	$ (816,041)
210044	g.b.m.c.	$201,533,345	0.25	0.27	-2.12%	$ (4,267,765)	$ (1,553,645)	0.31	-0.42%	$ (839,722)
210048	howard county	$167,386,497	0.24	0.27	-2.12%	$ (3,544,655)	$ (1,290,403)	0.31	-0.42%	$ (697,444)
210009	johns hopkins	$1,292,515,919	0.25	0.29	-1.94%	$ (25,090,015)	$ (9,133,816)	0.32	-0.38%	$ (4,846,935)
210002	university of maryland	$863,843,449	0.25	0.29	-1.94%	$ (16,768,726)	$ (6,104,518)	0.33	-0.33%	$ (2,879,478)
210024	union memorial	$242,505,500	0.28	0.29	-1.94%	$ (4,707,460)	$ (1,713,712)	0.33	-0.33%	$ (808,352)
210033	carroll county	$138,209,278	0.29	0.31	-1.76%	$ (2,438,987)	$ (887,893)	0.35	-0.25%	$ (345,523)
210023	anne arundel	$310,117,075	0.29	0.32	-1.68%	$ (5,199,022)	$ (1,892,661)	0.36	-0.21%	$ (646,077)
210043	baltimore washington medica	$223,155,126	0.3	0.32	-1.68%	$ (3,741,130)	$ (1,361,928)	0.37	-0.17%	$ (371,925)
210051	doctors community	$136,225,391	0.32	0.34	-1.50%	$ (2,043,381)	$ (743,876)	0.38	-0.13%	$ (170,282)
210040	northwest	$142,186,717	0.33	0.36	-1.32%	$ (1,881,883)	$ (685,084)	0.40	-0.04%	$ (59,244)
210012	sinai	$429,154,679	0.33	0.37	-1.24%	$ (5,301,323)	$ (1,929,903)	0.40	-0.04%	$ (178,814)
210034	harbor	$124,002,220	0.35	0.37	-1.24%	$ (1,531,792)	$ (557,636)	0.40	-0.04%	$ (51,668)
210016	washington adventist	$161,698,669	0.34	0.36	-1.32%	$ (2,140,129)	$ (779,097)	**0.41**	0.00%	$ -
210049	upper chesapeake health	$148,917,096	0.33	0.37	-1.24%	$ (1,839,564)	$ (669,678)	0.41	0.00%	$ -
210063	um st. joseph	$216,335,128	0.34	0.37	-1.24%	$ (2,672,375)	$ (972,856)	0.41	0.00%	$ -
210001	meritus	$187,434,497	0.36	0.38	-1.15%	$ (2,149,984)	$ (782,684)	0.41	0.00%	$ -
210005	frederick memorial	$189,480,763	0.36	0.38	-1.15%	$ (2,173,456)	$ (791,229)	0.42	0.00%	$ -
210011	st. agnes	$239,121,556	0.36	0.39	-1.06%	$ (2,531,875)	$ (921,709)	0.42	0.00%	$ -
210018	montgomery general	$87,652,208	0.37	0.39	-1.06%	$ (928,082)	$ (337,861)	0.42	0.00%	$ -
210008	mercy	$233,163,594	0.38	0.40	-0.97%	$ (2,263,058)	$ (823,848)	0.44	0.00%	$ -
210010	dorchester	$25,127,935	0.4	0.40	-0.97%	$ (243,889)	$ (88,786)	0.44	0.00%	$ -
210027	western maryland health syste	$184,484,266	0.38	0.41	-0.88%	$ (1,627,802)	$ (592,588)	0.44	0.00%	$ -
210055	laurel regional	$77,501,975	0.40	0.41	-0.88%	$ (683,841)	$ (248,947)	0.45	0.00%	$ -
210015	franklin square	$285,691,170	0.38	0.41	-0.88%	$ (2,520,804)	$ (917,678)	0.46	0.00%	$ -
210057	shady grove	$228,731,775	0.42	0.45	-0.53%	$ (1,210,933)	$ (440,830)	0.48	0.00%	$ -
210038	ummc midtown	$133,787,811	0.44	0.46	-0.44%	$ (590,240)	$ (214,872)	0.49	0.00%	$ -
210006	harford	$47,089,618	0.48	0.49	-0.18%	$ (83,099)	$ (30,252)	**0.51**	0.03%	$ 15,697
210037	easton	$94,828,132	0.45	0.48	-0.26%	$ (251,016)	$ (91,380)	0.52	0.07%	$ 63,219
210058	rehab & ortho	$69,104,846	0.47	0.49	-0.18%	$ (121,950)	$ (44,395)	0.53	0.10%	$ 69,105
210032	union hospital of cecil count	$67,852,189	0.49	**0.51**	0.00%	$ -	$ -	0.54	0.13%	$ 90,470
210039	calvert	$67,385,287	0.48	0.51	0.00%	$ -	$ -	0.55	0.17%	$ 112,309
210003	prince george	$177,243,165	0.50	0.52	0.00%	$ -	$ -	0.55	0.17%	$ 295,405
210017	garrett county	$18,724,074	0.50	0.53	0.00%	$ -	$ -	0.57	0.23%	$ 43,690
210056	good samaritan	$180,861,011	0.52	0.54	0.00%	$ -	$ -	0.57	0.23%	$ 422,009
210029	hopkins bayview med ctr	$356,396,901	0.55	0.58	0.00%	$ -	$ -	0.60	0.33%	$ 1,187,990
210028	st. mary	$69,520,305	0.55	0.58	0.00%	$ -	$ -	0.61	0.37%	$ 254,908
210060	ft. washington	$17,776,133	0.55	0.58	0.00%	$ -	$ -	0.61	0.37%	$ 65,179
210061	atlantic general	$38,640,762	0.58	0.59	0.00%	$ -	$ -	0.62	0.40%	$ 154,563
210035	charles regional	$76,338,049	0.59	0.61	0.00%	$ -	$ -	0.63	0.43%	$ 330,798
210013	bon secours	$78,212,787	0.64	0.65	0.00%	$ -	$ -	0.68	0.60%	$ 469,277
210030	chestertown	$29,416,674	0.81	0.82	0.00%	$ -	$ -	0.84	1.00%	$ 294,167
210045	mccready	$3,734,618	1	1	0.00%	$ -	$ -	1.00	1.00%	$ 37,346
Total		$ 8,961,031,432				$ (123,076,937)	$ (44,805,157)			$ (13,091,330)
Penalty						-$123,076,937	-$44,805,157			**-$16,997,460**
% Inpatient										**-0.2%**
Reward						$0	$0			**$3,906,130**
Overall Limit for Reductions as % of Statewide Total Inpatient Revenue						**-0.50%**				
Overall Limit for Reductions as $						**-$44,805,157**				
Adjustment Ratio							2.7469			

Appendix IV: MHAC, QBR and RRIP Consolidated Modeling Results for RY 2017

ID	Hospital Name	Estimated Inpatient Revenue (FY15*2.6%)	MHAC (Below Target)	MHAC (Above Target)	QBR	RRIP	Net Impact (Below Target)		Net Impact (Above Target)	
210019	peninsula regional	$233,728,496	-2.56%	-0.58%	-0.84%	-0.78%	-4.17%	$ (9,748,939)	-2.2%	$ (5,131,655)
210004	holy cross	$319,596,342	-2.56%	-0.58%	-0.14%	-1.06%	-3.76%	$ (12,019,345)	-1.8%	$ (5,705,751)
210062	southern maryland	$163,208,213	-2.38%	-0.50%	-2.00%	-0.05%	-4.43%	$ (7,228,668)	-2.5%	$ (4,156,514)
210016	washington adventist	$161,698,669	-1.32%	0.00%	-0.31%	-0.96%	-2.60%	$ (4,201,931)	-1.3%	$ (2,061,802)
210001	meritus	$187,434,497	-1.15%	0.00%	-0.62%	-0.71%	-2.47%	$ (4,637,888)	-1.3%	$ (2,487,904)
210022	suburban	$181,410,188	-2.47%	-0.58%	-0.62%	-0.17%	-3.26%	$ (5,918,262)	-1.4%	$ (2,494,590)
210048	howard county	$167,386,497	-2.12%	-0.42%	-1.04%	0.10%	-3.06%	$ (5,129,694)	-1.4%	$ (2,282,483)
210033	carroll county	$138,209,278	-1.76%	-0.25%	-0.25%	-0.27%	-2.28%	$ (3,151,978)	-0.8%	$ (1,058,514)
210005	frederick memorial	$189,480,763	-1.15%	0.00%	0.27%	-0.62%	-1.49%	$ (2,831,295)	-0.3%	$ (657,839)
210049	upper chesapeake health	$148,917,096	-1.24%	0.00%	0.25%	-0.50%	-1.48%	$ (2,205,423)	-0.2%	$ (365,859)
210037	easton	$94,828,132	-0.26%	0.07%	0.31%	-1.74%	-1.70%	$ (1,615,380)	-1.4%	$ (1,301,145)
210044	g.b.m.c.	$201,533,345	-2.12%	-0.42%	-0.79%	0.28%	-2.63%	$ (5,291,523)	-0.9%	$ (1,863,480)
210035	charles regional	$76,338,049	0.00%	0.43%	0.11%	-0.95%	-0.84%	$ (642,198)	-0.4%	$ (311,400)
210009	johns hopkins	$1,292,515,919	-1.94%	-0.38%	0.76%	-0.38%	-1.56%	$ (20,104,183)	0.0%	$ 138,897
210002	university of maryland	$863,843,449	-1.94%	-0.33%	0.21%	-0.22%	-1.95%	$ (16,821,137)	-0.3%	$ (2,931,889)
210010	dorchester	$25,127,935	-0.97%	0.00%	0.81%	-0.52%	-0.68%	$ (171,819)	0.3%	$ 72,070
210060	ft. washington	$17,776,133	0.00%	0.37%	-0.70%	-0.30%	-1.00%	$ (178,272)	-0.6%	$ (113,093)
210024	union memorial	$242,505,500	-1.94%	-0.33%	-0.28%	0.70%	-1.52%	$ (3,690,378)	0.1%	$ 208,730
210015	franklin square	$285,691,170	-0.88%	0.00%	-0.43%	-0.22%	-1.54%	$ (4,396,594)	-0.7%	$ (1,875,789)
210040	northwest	$142,186,717	-1.32%	-0.04%	-0.59%	0.45%	-1.46%	$ (2,074,849)	-0.2%	$ (252,210)
210003	prince george	$177,243,165	0.00%	0.17%	-1.68%	0.37%	-1.31%	$ (2,329,329)	-1.1%	$ (2,033,924)
210057	shady grove	$228,731,775	-0.53%	0.00%	-0.57%	-0.11%	-1.21%	$ (2,765,307)	-0.7%	$ (1,554,374)
210055	laurel regional	$77,501,975	-0.88%	0.00%	-0.70%	0.61%	-0.98%	$ (757,628)	-0.1%	$ (73,787)
210043	baltimore washington medi	$223,155,126	-1.68%	-0.17%	0.25%	-0.10%	-1.53%	$ (3,406,884)	0.0%	$ (37,679)
210018	montgomery general	$87,652,208	-1.06%	0.00%	-0.49%	0.49%	-1.05%	$ (920,004)	0.0%	$ 8,078
210011	st. agnes	$239,121,556	-1.06%	0.00%	-0.49%	0.52%	-1.02%	$ (2,441,680)	0.0%	$ 90,195
210032	union hospital of cecil cou	$67,852,189	0.00%	0.13%	0.21%	-0.41%	-0.21%	$ (139,930)	-0.1%	$ (49,461)
210034	harbor	$124,002,220	-1.24%	-0.04%	0.16%	0.10%	-0.98%	$ (1,217,444)	0.2%	$ 262,680
210063	um st. joseph	$216,335,128	-1.24%	0.00%	0.00%	0.55%	-0.69%	$ (1,482,185)	0.6%	$ 1,190,190
210012	sinai	$429,154,679	-1.24%	-0.04%	0.07%	0.33%	-0.83%	$ (3,580,370)	0.4%	$ 1,542,138
210051	doctors community	$136,225,391	-1.50%	-0.13%	0.42%	1.00%	-0.08%	$ (111,127)	1.3%	$ 1,761,972
210023	anne arundel	$310,117,075	-1.68%	-0.21%	0.69%	0.26%	-0.72%	$ (2,238,516)	0.7%	$ 2,314,428
210013	bon secours	$78,212,787	0.00%	0.60%	-0.93%	1.00%	0.07%	$ 51,952	0.7%	$ 521,229
210061	atlantic general	$38,640,762	0.00%	0.40%	0.00%	-0.18%	-0.18%	$ (67,929)	0.2%	$ 86,634
210006	harford	$47,089,618	-0.18%	0.03%	0.76%	-0.42%	0.16%	$ 77,570	0.4%	$ 176,365
210029	hopkins bayview med ctr	$356,396,901	0.00%	0.33%	-0.75%	0.17%	-0.58%	$ (2,062,096)	-0.2%	$ (874,107)
210038	ummc midtown	$133,787,811	-0.44%	0.00%	0.09%	0.28%	-0.07%	$ (98,275)	0.4%	$ 491,965
210008	mercy	$233,163,594	-0.97%	0.00%	0.67%	0.47%	0.17%	$ 397,420	1.1%	$ 2,660,479
210027	western maryland health sy	$184,484,266	-0.88%	0.00%	0.60%	-0.10%	-0.38%	$ (705,492)	0.5%	$ 922,311
210045	mccready	$3,734,618	0.00%	1.00%	0.00%	1.00%	1.00%	$ 37,346	2.0%	$ 74,692
210056	good samaritan	$180,861,011	0.00%	0.23%	-0.11%	0.12%	0.01%	$ 19,381	0.2%	$ 441,390
210039	calvert	$67,385,287	0.00%	0.17%	0.24%	0.92%	1.16%	$ 783,353	1.3%	$ 895,662
210030	chestertown	$29,416,674	0.00%	1.00%	0.41%	0.85%	1.27%	$ 372,146	2.3%	$ 666,313
210058	rehab & ortho	$69,104,846	-0.18%	0.10%	0.00%	-0.16%	-0.34%	$ (232,018)	-0.1%	$ (40,964)
210017	garrett county	$18,724,074	0.00%	0.23%	0.68%	0.23%	0.91%	$ 170,008	1.1%	$ 213,698
210028	st. mary	$69,520,305	0.00%	0.37%	1.00%	1.00%	2.00%	$ 1,390,406	2.4%	$ 1,645,314
Total		**$ 8,961,031,432**								

Net Total Adjustment	$ (133,316,391)	$ (23,330,783)
Max Reduction	-4.4%	-2.5%
Percent Inpatient Rev	-1.5%	-0.3%
Percent Total Rev	-0.89%	-0.16%

Draft Recommendation:

Funding of Statewide Infrastructure, and Planning of Regional Partnerships for Health System Transformation under the Budget Reconciliation and Financing Act of 2014

March 11, 2015

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

This is a draft recommendation to be presented at the March 11, 2015 HSCRC public meeting. A final recommendation is expected to be presented at the April 15, 2015 meeting. Please submit any comments on or before April 3, 2015 to Steve Ports at Steve.Ports@Maryland.gov.

Funding of Statewide Infrastructure, and Planning of Regional Partnerships for Health System Transformation under the Budget, Reconciliation, and Financing Act of 2014

Overview

In accordance with the provisions of the Budget Reconciliation and Financing Act of 2014 (BRFA), this recommendation is to authorize Commission staff to increase rates (in FY 2015) effective May 1, 2015 to provide up to $15 million for the purpose of funding the planning of regional partnerships for health system transformation throughout the State, along with statewide infrastructure to support care management, transitions, coordination, and planning.

Background

During the 2014 Legislative Session, the General Assembly adopted the BRFA of 2014. This legislation provides that the Health Services Cost Review Commission ("HSCRC" or "Commission") may include an additional $15,000,000 in hospital revenue when determining hospital rates that are effective in fiscal year 2015 for the purpose of:

> (1) Assisting hospitals in covering costs associated with the implementation of Maryland's all–payer model contract; or
>
> (2) Funding of statewide or regional proposals that support the implementation of Maryland's all–payer model contract.

Statewide or regional proposals for funding are to be submitted to the Commission and the Department of Health and Mental Hygiene ("the Department" or "DHMH") for approval. The Department and the Commission are required to establish a committee to review regional proposals and make recommendations to the Department and the Commission for funding. The review committee is required to include representatives from the Department and the Commission as well as subject matter experts, including individuals with expertise in areas such as public health, community–based health care services and support, primary care, long–term care, end–of–life care, behavioral health, and health information technology.

The Commission may take action on a statewide or regional proposal that has been reviewed by the committee and approved by the Commission and the Department.

Rate Adjustment Request

Beginning in late 2013, the HSCRC convened an Advisory Council to develop Guiding Principles for implementation of the new All Payer Model. The Advisory Council put forth its Final Report on January 31, 2014.

The Advisory Council indicated that HSCRC should work with providers, payers, and consumers to analyze data for identifying opportunities that would improve patient care and health outcomes. In particular, patients with complex medical needs and chronic conditions, who are frequent users of the health care system, can be appropriately identified without infringing on their confidentiality rights, and they can be targeted for better care coordination and health improvement.

The recommendations of the Advisory Council are summarized below:

- Focus on meeting early Model requirements (Note: including through hospitals being on global budgets supported by multi-disciplinary care coordination especially for high-risk Medicare fee-for-service patients, to enable meeting the state-wide ceilings and Medicare savings requirements
- Meet budget targets while making important investments in infrastructure and providing flexibility for private sector innovation
- HSCRC should play the roles of regulator, catalyst and advocate
- Consumers should be involved in planning and implementation
- Physician and other provider alignment is essential
- An ongoing, transparent public engagement process is needed

In the Advisory Council meetings, members advised that care coordination is an area in which we should focus attention on models that have demonstrated success rather than on many untested and different strategies. The Data and Infrastructure Work Group and Physician Alignment and Engagement Work Group recommended considering shared infrastructure and common approaches to care coordination. Based on this advice, the HSCRC's goal is to facilitate consideration of some shared infrastructure and common approaches that might limit confusion and improve effectiveness for providers and patients.

Subsequently, the Care Coordination Work Group was created and has been discussing opportunities that can best provide success in meeting the all-payer model requirements. From the deliberations thus far, it is clear that access to robust data and

improved care coordination are considered major factors in success. This success will require hospitals, community-based providers, long-term care, and post-acute care providers to work together to effectively coordinate patient care, reducing the need for hospitalizations.

Below are three proposed uses of BRFA funds that are designed to reach the goals of improving regional collaboration for care coordination, improving statewide infrastructure to enable proven care coordination strategies to be successful, and providing evaluation and planning resources.

Planning Grants for Regional Partnerships for Health System Transformation

In order to improve population health, it is essential that regional collaborations develop across the State. Enabling Maryland's health care system to be highly reliable, highly efficient, and a point of pride in our communities will require increased collaboration between health systems, payers, community hospitals, ambulatory physician practices, long-term care providers, and many other community-based organizations. It will also require effectively engaging patients and consumers.

In order to achieve these goals and to pave a way for success of the All-Payer Model, the Department, in collaboration with the HSCRC, released a Request for Proposals ("RFP") on February 9, 2015 for funding to support planning, development initiatives, and operational plans for regional partnerships for health system transformation. Applications are due by April 15, 2015.

The RFP invites proposals to develop partnerships capable of identifying and addressing their regional needs and priorities and, in turn, shaping the future of health care in Maryland. The proposals should include developing care coordination and population health priorities, determining what resources are needed and available, and how resources and strategies should be deployed. While the model concept itself should focus on particular patient populations (e.g., patients with multiple chronic conditions and high resource use, frail elders with support requirements, dual-eligibles with high resource needs), the proposals may include a strategy for improving overall population health in the region over the long-term, with particular attention paid to reducing risk factors. This population health strategy should incorporate and build upon those existing population health action plans developed by Local Health Improvement Coalitions together with Community Health Needs Assessments, and

expand to address chronic conditions and frail elders, and other specific resource needs relevant to aging populations that are proven or expected to move Maryland toward meeting the goals and requirements of the All-Payer Model.

Under the RFP, DHMH and HSCRC will provide a maximum of $400,000 for each approved application. The application process will be competitive, with five or more awards being made in the State. It is anticipated that up to a total of $2.5 million will be used to fund selected proposals. Some areas of the State may require more time to prepare for this undertaking or may benefit from joining forces with other applicants. Funding will be allocated via HSCRC-approved rate increases for hospitals participating in partnerships that receive awards. For this reason, applications are to be submitted by a hospital in consultation with partner organizations. Individual applicant partners may be included in more than one application due to the nature of the process.

The evaluation committee will provide preference to those models that include the following characteristics/features:

- A comprehensive, diverse set of partners with standing in the region
- Multiple target high-cost conditions/populations, with initial focus on Medicare
- Integrating primary care, prevention, and addressing multiple determinants of health
- Sustainability concept that builds on the All Payer Model and other delivery/financing models

Successful bidders are required to submit an interim report to the Department and HSCRC by September 1, 2015, and a final report is due on December 1, 2015.

Funding of Common Care Coordination Infrastructure to Provide Support on a Statewide Basis

The Care Coordination Work Group has been considering statewide, regional and provider-based strategies to improve care coordination, transitions, management, and planning. The Work Group to date has clearly expressed that access to meaningful, actionable data is one important tool to achieve effective care coordination. The Work Group has identified a two-track approach for using data to inform and support care coordination:

Track 1 – Use Existing Data Sources: First, it is important to use information from *existing data sources* that could be used to identify patients with the most complex medical needs. These data would include data currently available through CRISP such as real time Hospital Admit, Discharge, and Transfer (ADT), hospital inpatient and outpatient data available on a monthly basis through the HSCRC abstract, and potentially other clinical data available through CRISP. Additionally, other sources of data should be evaluated for possible use in these efforts, including: pharmacy data obtained from pharmacy benefit managers (PBMs), Outcome and Assessment Information Set (OASIS) data on home care, Minimum Data Set (MDS) records on nursing home care, and other information sources.

Track 2 – Acquire Medicare data: On a parallel track, Maryland should take steps as soon as possible to acquire Medicare claims data under its existing CMMI grant. Medicare data that include physician encounters as well as skilled nursing facility and other post-acute providers linked with hospital data, clinical data, ADT, and HSCRC abstract data will create powerful tools for care coordination.

The Work Group is currently considering opportunities for investment in care coordination. One of the sources of such investment is utilization of the funds referred to in BRFA. Some of the potential priorities for such funding include:

- Building/securing a data infrastructure to facilitate identification of individuals who would benefit from care coordination
- Encourage patient-centered care and patient engagement including sharing common information regarding patient care among providers and care coordinators
- Encouraging collaboration among providers (including social services, behavioral health, long-term care, post-acute care providers), patient advocates, public health, faith-based initiatives
- Connect providers to CRISP

The Work Group is continuing to consider, prioritize, and quantify the cost of these functions. The Work Group anticipates providing more detail on such strategies and recommendations prior to the April Commission meeting. Staff anticipate that up to

$12 million may be used for this purpose, based on recommendations of the Work Group.

Evaluation and Planning Resources

On October 15, 2014, the Commission approved a staff recommendation to increase rates of approximately $1 million to fund consulting and expert resource needs to support more detailed planning, evaluation, and stakeholder input relative to provider alignment and care coordination initiatives and infrastructure needs through CRISP. Under a Memorandum of Understanding with CRISP, the vendors obtained under this recommendation have been critical in bringing the Care Coordination Work Group activities to their current level of progression, as well as in considering options, challenges, and barriers for establishing regional integrated care networks in Maryland. The October recommendation specifically stated that BRFA funds should be used to support this activity, since it is directly related to supporting statewide and regional planning and infrastructure.

The approved October recommendation provided that the planning and implementation funding shall reduce the amount of BRFA funding available for implementation of the All-Payer Model from $15 million to $14 million. This is because the HSCRC will have allocated revenue capacity to implement a planning and implementation process that is needed to ensure stakeholder and public input into the approach that will be recommended to the Commission.

The Maryland Hospital Association supported this funding approach but has advocated for caution to ensure that funded activities benefit hospitals in the implementation of the new All-Payer Model. HSCRC staff agrees with this cautious approach, and we have focused our recommendations to limit resource allocation to those activities that result from the recommendations of the Advisory Council, the Work Groups, and public input received during the planning process.

Draft Recommendation

Based on the above, HSCRC staff recommends that hospital rates be increased in FY 2015 beginning May 1, 2015 to provide up to $15 million to support:

- Planning grants for regional partnerships for health system transformation (up to $2.5 million) - Rates will be increased only for those hospitals that are part of a collaborative RFP chosen by the review committee and approved by the Department and the Commission pursuant to the process outlined in the RFP.

- Common care coordination infrastructure to provide support on a statewide basis for specific opportunities to improve care coordination and chronic condition management (up to $12 million) – Rates will be increased for all or a subset of hospitals to support this activity.

- The existing engagement of resources to assist (in conjunction with stakeholders) in further evaluation and planning of possible statewide infrastructure and approaches for care coordination and provider alignment ($1 million) - Rates will be increased for all or a subset of hospitals to support this activity.

Refinement of the allocation of funds to projects that support common care coordination infrastructure will be provided in further detail at the April Commission meeting.

Demonstration of MHCC's Web-based Consumer Guide

The Demonstration will be provided at the Commission meeting

Work Group Updates

Slides will be presented at the Commission Meeting

Legislative Update

The Legislative Update will be presented at the Commission Meeting

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals

Authority: Health-General Article, § 19-217; Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulations **.08** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on March 11, 2015, notice of which was given pursuant to General Provisions Article, § 3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about June 2, 2015.

Statement of Purpose

The purpose of this action is to conform to the requirements set forth in Chapter 263, Acts of 2014, effective July 1, 2014, that require hospitals to notify the Commission, in writing, within 30 days before executing any financial transaction, contract, or other agreement that would result in more than 50% of all corporate voting rights or governance reserve powers being transferred to or assumed by another person or entity.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or (410) 764-2576, or fax to (410) 358-6217, or email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until May 18, 2015. A hearing may be held at the discretion of the Commission.

.08 Notification of Certain Financial Transactions.

A. (text unchanged)

(1) Pledge more than 50 percent of the operating assets of the facility as collateral for a loan or other obligation*; or*

(2) Result in more than 50 per cent of the operating assets of the facility being sold, leased, or transferred to another person or entity[.]*; or*

(3) Result in more than 50 percent of all corporate voting rights or governance reserve powers being transferred to or assumed by another person or entity.

B. (text unchanged)

(1) [The name and address of the person or entity to whom the operating assets of the facility are being sold, leased, transferred, or pledged as collateral for a loan or other obligations; and]*The name and address of the person or entity to whom:*

(a) The operating assets of the facility are being sold, leased, transferred, or pledged as collateral for a loan or other obligation; or

(b) The corporate voting rights or governance reserve powers are being transferred or assumed.

C. – E. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

State of Maryland
Department of Health and Mental Hygiene

John M. Colmers
Chairman

Herbert S. Wong, Ph.D.
Vice-Chairman

George H. Bone, M.D.

Stephen F. Jencks, M.D., M.P.H.

Jack C. Keane

Bernadette C. Loftus, M.D.

Thomas R. Mullen

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Donna Kinzer
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

David Romans
Director
Payment Reform and Innovation

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Sule Calikoglu, Ph.D.
Deputy Director
Research and Methodology

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **March 4, 2015**

RE: **Hearing and Meeting Schedule**

April 15, 2015	Time to be determined, 4160 Patterson Avenue HSCRC/MHCC Conference Room
May 13 , 2015	Time to be determined, 4160 Patterson Avenue HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:45 a.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at http://www.hscrc.maryland.gov/commission-meetings-2015.cfm

Post-meeting documents will be available on the Commission's website following the Commission meeting.